



# **HCBS Provider Enrollment Checklist** **for NEW HCBS Waiver Providers**



This checklist provides ALL of the required forms and documentation that will need to be completed and submitted to the appropriate [Area Agency on Aging and Disability \(AAAD\)](#).

## **Enrollment Forms to be Completed by Potential Provider:**

### **REQUIRED FORMS -One (1) Copy of All Forms with Original Signature**

- \_\_\_ [No. 3 Group Application](#)
- \_\_\_ [Provider Participation Agreement](#)
- \_\_\_ [Substitute W-9 Form](#)
- \_\_\_ Signed [Memorandum of Agreement between TCAD and Provider with Attachment A](#)  
*Attachment A is the Memorandum of Agreement between TCAD and the AAAD.*
- \_\_\_ Signed [Provider Agreement between TennCare and Provider with Attachment A](#)  
*Attachment A is the Disclosure of Ownership and Control Interest.*

### **OPTIONAL FORMS – One (1) Copy of Form with Original Signature**

- \_\_\_ [Direct Deposit Application \(Automated Clearing House\)](#) with VOIDED Check

## **Copies of Documents needed from Potential Provider:**

### **REQUIRED FORMS -One (1) Copy of All Forms**

- \_\_\_ Documentation verifying financial capacity to operate (IE: line of credit, tax return, etc.)
- \_\_\_ Disclosure of Ownership and Control Interest Statement
- \_\_\_ Proof of liability insurance (\$500,000)
- \_\_\_ Verification of license to do business for Pest Control, Minor Home Modifications, Assistive Technology.
- \_\_\_ Membership on the Board of Directors (if applicable)
- \_\_\_ Facility License(s) from other Departments (if applicable)

## **Documents for Review at time of Enrollment:**

### **REQUIRED FORMS -One (1) Copy of All Forms**

- \_\_\_ [Standards Assessment and Documentation Review](#) (Document will be used for the AAAD Annual Quality Review)
- \_\_\_ [Medicaid Waiver Provider Orientation Guide](#) (Initial overview of HCBS Program with the agreement of Provider to complete an agency specific Policy and Procedure Manual before the AAAD Annual Quality Review)
- \_\_\_ [Service Delivery Area\(s\) for Statewide HCBS Waiver Providers](#) (Identifies each County the Provider will serve)